the absolute validity of the data to a slight degree, I do not think it has much bearing on the more important comparative rankings by state. If a difference of a year or two would affect the results to any pronounced degree, that would require significantly unstable and erratic population behavior. Empirical observation of population estimates does not reveal such a pattern. Indeed, a linear assumption seems far more warranted as I see it.

Finally, the question of incidence data: Mr Levy's assumption is correct, I used residence data. Actually, the assumption of residence is rather fluid (at least here in California) and it is pretty difficult *not* to be classed as a resident if you have made any efforts towards establishing residence or, in some cases, even expressed an interest.

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Reporting Requirements for Reye's Syndrome and AIDS in California

TO THE EDITOR: Your California readers may be interested in recent changes in the reporting requirements for Reye's syndrome and acquired immunodeficiency syndrome (AIDS).

Effective January 1, 1985, Section 304.5 of the California Health and Safety Code mandates the reporting of Reye's syndrome to public health authorities within seven days of diagnosis. Until now, the California Department of Health Services (DHS) has depended on voluntary reporting by physicians and hospitals to obtain data about the occurrence, severity and distribution of Reye's syndrome in California.

Over the last 15 years, between 15 and 25 cases of Reye's syndrome have been reported each year. About a third of these cases have been fatal. However, the actual incidence is believed to be substantially greater than voluntary reporting indicates. It is hoped that the new law will improve epidemiologic information about the syndrome and, consequently, provide better clues about its etiology—especially with regard to the presumed association with aspirin. It is also hoped that better reporting of Reye's syndrome will allow health departments to monitor the effectiveness of the warning label that the aspirin industry has recently agreed to place on aspirin containers.

AIDS was made a reportable disease (Section 2503, California Administrative Code, Title 17, California Health and Safety Code) in March 1983. Initial reporting of this disease seemed to be relatively complete; however, in the past year there has arisen increasing evidence that more and more physicians do not report AIDS because they fear that the information will not remain confidential. This is not true. The DHS regards reports on patients, whatever the disease, as medical records and treats them with the strictest confidentiality. This confidentiality is guaranteed by law. Information from case reports is used only for statistical purposes and to protect the public health.

It is important that AIDS case reporting be as complete as possible so that trends in the spread of the disease, both geographically and temporally, as well as among various segments of the population, can be monitored. These data also serve to identify new risk factors should they emerge.

The prescribed forms for making these reports (the Confidential Morbidity Report) can be obtained from local health departments or the Infectious Disease Section of the California Department of Health Services.

Both Reye's syndrome and AIDS are important public health problems. A great deal more must be learned about both conditions, and we urge all physicians to comply with the reporting requirements for these diseases.

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Neonatal Seborrheic Dermatitis

TO THE EDITOR: The distinction between seborrheic dermatitis and atopic dermatitis could be very difficult, if not impossible, to make in very young infants. Moss suggests that seborrheic dermatitis appears earlier in life—the first few weeks rather than two to three months—than atopic dermatitis.[1] I would like to report my experience with a neonate who presented with seborrheic dermatitis in the first few days of life. To my knowledge, this is the youngest infant with seborrhea reported in the literature.

Report of a Case

A male infant weighing 3,810 grams was born at term to a gravida 3, para 2, 33-year-old mother following an uncomplicated pregnancy and normal vaginal delivery. There was no history of birth trauma. Apgar scores were 8 and 9 at one minute and five minutes, respectively. At eight hours of age, an erythematous rash appeared on the face and the postauricular areas. Twenty-four hours later, the rash became scaly with mild involvement of the scalp. The neonate looked quite comfortable and the lesions did not seem to be pruritic. There was no family history of atopy. The infant was seen in consultation by a pediatric dermatologist who agreed with the diagnosis of seborrheic dermatitis. After treatment with 0.5% hydrocortisone cream there was pronounced improvement and subsidence of the rash in two to three days.

The diagnosis of seborrheic dermatitis in this case was based on its early appearance in life, its involvement of the scalp and postauricular area, its nonpruritic nature and its rapid response to treatment with steroid cream. An eosinophil count is not of much aid in the differentiation of seborrheic and atopic dermatitis.[2] When the diagnosis is in doubt, total and specific IgE levels will aid in their differentiation; these levels are elevated in patients with atopic but not seborrheic dermatitis.[2] The distinction between these two conditions is important as the latter has a more favorable prognosis and a lesser chance of recurrence.

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